CONTENTS

CHAPTER 1. ADMINISTRATION OF RMS (REHABILITATION MEDICINE SERVICE)

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1.01 STATEMENT OF POLICY

a. RMS is an organizational unit characterized by the utilization of physical, mental, psychosocial, educational and vocational services for the prevention and reduction of disability. In order to prepare patients for optimum independence in their environments, diagnosis, treatment and prevention are utilized.

(1) Sections comprising the service employ the following treatment modalities:

(a) Medical,

(b) Physical,

(c) Cognitive,

(d) Psychosocial,

(e) Educational, and

(f) Vocational.

(2) The Rehabilitation Program consists of three components:

(a) Patient care,

(b) Education, and

(c) Research.

b. As one of the major clinical services in VA (Department of Veterans Affairs), RMS has a three-fold mission:

(1) RMS emphasizes comprehensive rehabilitation of the veteran. Using an interdisciplinary approach, RMS aims to prevent or limit impairment, disabilities and handicaps of individual patients while improving their functional abilities, independence, and quality of life. The standard of care shall be directly comparable to the current state-of-the-art available in the academic and private sectors of health care. The quality and appropriateness of services offered is ensured throughout RMS by an ongoing process of monitoring and feedback.

(2) In order to support patient care at a high level of competence, RMS is committed to the education of rehabilitation professionals necessary to carry out those functions. In addition, RMS participates in the education of other health care professionals and of society as a whole.

(3) RMS supports, encourages, and carries out clinical and basic science research directed toward the advancement of the art and science of medical rehabilitation.

1.02 GENERAL PROVISIONS

a. RMS has a defined philosophy with stated goals and objectives for rehabilitation

which are in accordance with the VA facility's mission. Goals and objectives for each patient will be reviewed, evaluated and revised according to:

(1) Patient needs,

(2) Established target dates, and

(3) Requirements of appropriate accreditation bodies.

b. RMS encourages investigation and implementation of new developments and practices in rehabilitation to enhance the quality of patient care. This will be accomplished through:

(1) Research,

(2) Education,

(3) Practical application of theory, and

(4) Contributions to professional literature.

c. Administrative Organization

(1) A medical center approved organizational chart and functional statement will delineate responsibility, authority, relationships of therapy sections, service delivery and accountability.

(2) A master staffing plan for RMS must be developed by the Chief or Acting Chief, RMS, which recommends the number, category and grade levels of personnel required to deliver care.

(3) These plans will be:

(a) Reviewed annually,

(b) Revised when appropriate in consultation with the appropriate governing body, and

(c) Proposed to and approved by the medical center Director.

(4) RMS, VA Central Office, will be contacted by the Chief, RMS, or designee for approval, prior to the implementation of any proposed organizational and major program changes made in RMS therapy sections.

d. RMS shall carry out quality assurance and peer review activities.

e. RMS will meet the standards for rehabilitation medicine services published in the manuals of accreditation under which the medical center is evaluated.

f. RMS will use qualified consultants for program planning, implementation and evaluation.

g. The Chief, RMS, will be a board certified physiatrist, unless otherwise authorized by VA Central Office. It is emphasized that the Chief, RMS, has the authority and responsibility for the clinical management of RMS programs.

(1) The Chief, RMS, is responsible for:

(a) The establishment of service goals,

(b) The planning and implementation of programs within the policies and procedures of VHA (Veterans Health Administration), and

(c) The quality of care provided by RMS staff physicians, residents and therapy staff.

(2) Program implementation is made in collaboration with appropriate services within the facility and, where applicable, with those in the community.

(3) Medical supervision for all therapy sections is provided by a physician.

(4) When a physiatrist has not been recruited, a physician designated by the medical center Director will serve as Acting Chief, RMS, until a qualified Chief, RMS, has been appointed with VA Central Office concurrence.

h. The Assistant Chief of RMS will be a board certified or eligible physiatrist, unless otherwise authorized by VA Central Office. This individual has the responsibility to carry out the mission and objectives of the department and duties delegated by the Chief, RMS; and in the absence of the Chief, RMS, becomes Acting Chief, RMS.

i. RMS staff physiatrists shall assist the Chief, RMS, in carrying out the mission of RMS Service.

(1) The staff physiatrists will be responsible primarily for:

(a) Inpatient care on RMS bed services,

(b) Prescribing treatment for in- and outpatients referred by consultations; and

(c) Providing special tests such as EMG (electromyography) and other electrodiagnostic procedures.

(2) The physiatrists work closely with the patients, their families and all rehabilitation team members which include:

(a) Rehabilitation nurses,

(b) RMS therapists,

(c) Psychologists,

(d) Social workers,

(e) Speech pathologists, and

(f) Physicians from other services.

(3) If a residency program is in effect, the physiatrists are responsible for the teaching of the residents and the patient care provided by the residents.

(4) The physiatrists participate in administration, committees, and the general teaching functions as delegated by the Chief, RMS.

j. RMS Administrator/Coordinator

(1) The RMS Administrator/Coordinator is responsible for:

(a) Directing, organizing and evaluating the administrative operation of RMS, under the supervision of the Chief, RMS; and

(b) Upon request, representing RMS in interdisciplinary planning groups at many levels to facilitate the planning, delivery and re-evaluation of integrated comprehensive care.

(2) This position may be established in medical centers only where the following criteria are met:

(a) There is a designated RMS Bed Service;

(b) The medical center has an active comprehensive Rehabilitation Program, as evidenced by at least two of the following characteristics:

1. There are a minimum of three therapy sections in RMS with at least 13 total FTEE (full-time employee equivalent) assigned to the service.

2. There is a medical school affiliation, with medical students and/or residents assigned at least 6 months out of the year.

3. New consultations to RMS (for all therapy services) number at least 60 per month, or

4. The medical center has one or more authorized, specialized programs which require intensive, interdisciplinary rehabilitation services. These may include:

a. Blind Rehabilitation,

b. CRC (Comprehensive Rehabilitation Center),

c. GRECC (Geriatric Research, Education and Clinical Centers),

d. SCI (Spinal Cord Injury), or

e. STAMP (Special Teams for Amputation, Mobility and Prosthetics/Orthotics); and

(c) The Chief, RMS, is active in clinical and academic medicine, as evidenced by any one of the following:

1. Providing primary attending physician care at least 6 months of the year for an inpatient service of not fewer than six beds.

2. Being the primary outpatient medicine care provider for patients with specific diagnoses, covering not less than 12 outpatient visits per week, and/or

3. Being Principal Investigator on a funded merit review research grant.

4. Serving on medical school faculty, and/or supervising resident physicians.

(3) Requests for exceptions to this policy should be addressed through the appropriate Regional Director to the Director, RMS (117B), VA Central Office, 810 Vermont Avenue, N.W., Washington, DC 20420.

NOTE: In line with good position management and considering current medical center requirements and priorities, RMS should determine, with local management, the need to establish or continue a RMS Administrator/Coordinator position.

k. Therapy section supervisors assist in setting the guidelines of RMS policies and procedures. They are responsible for the total management, organization, administration, supervision, and professional functions, of their respective sections.

l. The clinical training supervisor maintains contact with affiliating educational institutions and is responsible for the development, operation, revision and supervision of the clinical training programs in the clinical training supervisor's specific section.

m. The therapy staff will be competent, ethical providers of rehabilitative services.

(1) Rehabilitation therapy assistants or aides assist in the daily treatment of assigned patients under the supervision of rehabilitation therapists/specialists.

(2) Rehabilitation therapists, specialists, and assistants are responsible, within the limits of their academic preparation and approved scope of practice or clinical privileges, for the independent performance of their profession.

(a) A scopes of practice will be based on:

1. Professional standards of practice,

2. Documented academic education and training, and

3. Specific experience in the delivery of patient care.

(b) A scopes of practice is requested by the staff member, and approved under the provisions of the individual medical center policies.

n. Clerical support for RMS is provided by secretaries and clerks. The level of responsibility delegated to these positions is individually determined by the Chief, RMS, or RMS Coordinator, within established agency personnel practices.

1.03 RMS CONSULTATIONS, REFERRALS, PROGRESS REPORTS AND CLINICAL RECORDS

a. RMS personnel are responsible for complete, accurate and timely documentation of the veteran's rehabilitation care in the permanent medical record.

b. Veterans will be referred to RMS by means of Standard Form 513, Clinical Record - Consultation Sheet, or a form approved by the facility's Medical Records Committee. The medical center's RMS policy memorandum will specify method, mode and content of all referrals.

c. The consultation form will be completed with as much specificity as possible.

(1) RMS treatment programs will be prescribed or approved by a RMS physician and will be administered by the RMS staff according to clinical treatment plans.

(2) Evaluations may be completed by appropriate RMS staff based on referrals or requests from hospital team members with provisions that physician approval will be obtained within limits prescribed by local RMS policy and procedures, and governed by accrediting bodies.

d. The Chief, RMS, or physician designee, will record examination findings and recommendations on the approved form and return it within time limits specified by VA medical center policy and accrediting body guides.

e. Evaluation and treatment will be initiated according to the time frame established in the medical center's RMS Policy and Procedures Manual. The respective specialties should be involved in the complete evaluation process.

(1) The initial assessment will include the establishment of measurable goals and the development of a treatment plan which includes discharge planning and patient education.

(2) There will be an interdisciplinary treatment plan developed jointly with the referring individual, the rehabilitation staff, and the patient and/or family.

(3) Regular and frequent assessments will be performed on an interdisciplinary basis including a revision of program goals as required by the patient's condition.

(4) Discharge planning will be an ongoing collaborative function of the interdisciplinary treatment team providing information for the post hospital plan.

f. Progress notes will be written in the veteran's clinical permanent medical record to reflect the patient's condition and progress towards the rehabilitation goals. Documentation frequency shall meet the standard set in the medical center's RMS policies and procedures which must be in accordance with the accrediting agency requirements for the medical center.

g. A final note shall be prepared by each contributing section and placed in the veteran's permanent medical record. The final note shall include, but not be limited to:

(1) A diagnosis and a treatment plan;

(2) Summation of treatment and response to treatment;

(3) Frequency of treatments given and duration of treatment;

(4) Status of the veteran upon termination;

(5) Follow up treatment, program goals/objectives;

(6) A statement regarding patient health education provided and, when applicable, home program instructions; and

(7) A statement regarding satisfactory understanding of the proper operation of all adaptive equipment provided to the patient.

h. One-visit Patients. The completed referral form will document evaluation of treatment services rendered to patients on a one-visit basis. The evaluation document will become a part of the patient's permanent medical record.

i. Forms by RMS may be over-printed as approved by local VA medical center's Medical Records Committee and/or the Forms Control Officer.

1.04 HEALTH, SAFETY AND SANITATION

Current health, safety and sanitation directives as they pertain to space, personnel, fabricated articles, equipment, supplies and utilities will be observed in RMS and included in the RMS Policies and Procedures Manual. Special attention will be given to the following areas:

a. Infection Control. Infection control programs will be instituted in compliance with the VA medical center's Infection Control Committee, and current CDC (Center for Disease Control) policies.

b. CMR (Consolidated Memorandum Receipt). All CMR-listed equipment used in RMS will be on a preventive maintenance program, calibrated as necessary and, when applicable, in compliance with the OSHA (Occupational Safety and Health Administration) standards. Documentation of the calibrations will be maintained in a prominent location in the appropriate RMS clinic and in the files of the facility Engineering Service.

c. Hazardous Items. Hazardous equipment and supplies will be used only in accordance with written safety and storage regulations that conform with both the agency directives, policies and guidelines as established by local policy. MSDS (Material Safety Data Sheets) will be available according to local policy.

d. Security. Security controls will be required for all clinical areas as dictated by medical center policy.

e. Fire and Safety. The medical center's fire and safety standards and disaster plans will be followed and a copy will be maintained in each RMS section and in the RMS office. RMS plans will be formulated consistent with medical center policy and reviewed annually by all service personnel. Annual staff development sessions will be held for infection control, safety, fire and the disaster plan.

f. Swimming Facilities. RMS safety rules and Federal Health Regulations are to be adhered to for the use of swimming facilities, on or off medical center grounds:

(1) Swimming instructors and life guards will be currently qualified in life saving techniques by a nationally recognized agency, such as the American Red Cross or YMCA (Young Men's Christian Association). Each RMS instructor or life guard will be certified in either the Emergency Water Safety or Lifeguard Training courses (or equivalent) depending upon the patient population being served.

(2) There will always be at least one such qualified person, properly attired, in the immediate pool area when the pool is in use by patients.

(3) With respect to the number of such qualified persons on duty at any one time, the ratio of such qualified persons to patients will be dictated by local needs.

g. CPR (cardiopulmonary resuscitation). Certification in CPR as per the American Heart Association is recommended for all RMS personnel who are involved in direct patient care. Yearly review of basic life support procedures should be made available to all RMS personnel.

1.05 VOLUNTEERS IN RMS

a. The services of volunteers may be utilized where appropriate to support staff efforts in RMS programs.

b. Volunteers will receive an appropriate description of their assignment and orientation by Voluntary Service prior to working on a RMS assignment.

c. Volunteers will be provided appropriate orientation and/or training in the RMS section to which they are assigned.

1.06 SUPPLIES AND EQUIPMENT

a. Supplies and equipment required for rehabilitation will be furnished and/or prescribed for eligible veterans.

b. Medical center equipment and supplies will be used primarily for the benefit of veterans participating in a RMS program. With recommendation of the RMS Chief and authorization of the medical center Director, equipment and supplies may be used by VA and non-VA individuals or organizations, provided this does not interfere with patient care, and meets safety, security and liability criteria.

1.07 AREAS AND FACILITIES

RMS areas and facilities are to be used primarily for the benefit of veterans participating in RMS programs. The Chief, RMS, or designee, is authorized to allow areas and facilities to be used by others for activities and meetings which do not interfere with patient programs. The authorization for utilization of RMS space must be in accordance with existing local medical center policy.

1.08 UNIFORMS

Uniforms for RMS personnel are required and will be issued except where local permission for deviation has been obtained.

1.09 RMS MANAGEMENT TEAM

a. The RMS Management Team consisting of the Chief, RMS Coordinator, and Section Supervisors, will meet regularly to plan, organize, staff, direct and monitor the professional and managerial activities of the service. The final responsibility is retained by the Chief, RMS.

b. Functions of the RMS Management Team are:

(1) To assure that RMS fulfills its mission to provide comprehensive rehabilitation care to all eligible veterans requiring such services within the limits of resources provided. Achievement of this care will be monitored through appropriate Quality Assurance monitors;

(2) To establish effective and efficient use of resources with continuous mechanisms for accountability;

(3) To participate in the medical center's annual budget plan by forecasting needs for:

(a) Existing and new programs,

(b) Personnel,

(c) Space,

(d) Supplies,

(e) Equipment,

(f) Educational resources, and

(g) Consultants;

(4) To assign patient treatment to appropriate sections or individuals properly skilled and credentialed for fulfilling patient rehabilitation goals;

(5) To facilitate interdisciplinary communication;

(6) To participate in the planning of new construction, additional space, remodeling of existing facilities, and in purchasing of major equipment; and

(7) To integrate and supplement educational objectives for staff development in the areas of professional, educational and management skills.

1.10 COMPONENTS OF RMS

Based on the needs of the veteran population served by VA facilities, the following Sections may be established within RMS:

a. Educational Therapy,

b. Kinesiotherapy,

c. Manual Arts Therapy (or Vocational Rehabilitation Therapy),

d. Occupational Therapy, and

e. Physical Therapy.

NOTE: In those facilities where a Recreation Therapist, Audiologist and/or a Speech Pathologist have not been established under a separate Service, they may be organizationally placed as a Section within RMS.

1.11 ANNUAL REPORT

Copies of service annual management briefing summaries for each fiscal year will be submitted to VA Central Office no later than 1 month after the summary submission to facility management. Other statistical reports will be submitted as directed by VA Central Office.